No. 87-173

Supreme Court, U.S.
FILED
SEP 21 1987
JOSEPH F. SPANIOL, JR.
CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1987

MASSACHUSETTS MEDICAL SOCIETY, et al.

Petitioners,

v.

MICHAEL S. DUKAKIS, et al.,

Respondents.

On A Petition For A Writ Of Certiorari
To The United States Court Of
Appeals For The First Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

Does the Medicare statute prohibit Massachusetts from limiting physician fees to Medicare beneficiaries at the Medicare-determined reasonable charge in order to protect elderly citizens against the costs of health care services.

LIST OF PARTIES

In addition to the parties listed in the caption, the following are additional respondents:

Russell J. Rowell, M.D.
Marilyn Griffin, M.D.
Ralph A. Deterling, Jr., M.D.
Louise Liang, M.D.
Melinda Milberg
Marian J. Ego
James French
Massachusetts Senior Action Council, Inc.[1/]
Massachusetts Association of Older Americans, Inc.[2/]

1/ A member organization of National Council of Senior Citizens, Inc.

2/ Legislative Council for Older Americans, Inc., is an affiliate of Massachusetts Association of Older Americans, Inc.

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STATUTORY PROVISIONS INVOLVED

In addition to the constitutional and statutory provisions listed in the Petition for Writ of Certiorari, the following sections of the Medicare Act are also involved:

42 U.S.C. §1395

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 U.S.C. §1395b

> Nothing contained in this subchapter shall be construed to preclude any state from providing, or any

individual from purchasing or otherwise securing protection against the cost of any health services.

STATEMENT OF THE CASE

Petitioners claim a conflict between the Massachusetts statute, Chapter 475 of the Acts of 1985, and the Health Insurance for the Aged Act, 42 U.S.C. §§1395 et seq., commonly known as the Medicare Act. Since petitioners have provided a description of each statute in their brief, respondents will not duplicate a complete description of the statutes involved but will simply address petitioners' omissions.

A. The Medicare Act.

The Medicare Act established a national health insurance program for people sixty-five years of age or over.

The purpose of this insurance program was not to regulate physicians (see 42 U.S.C. §1395) or to preclude state action in the field of insurance or cost-containment of health services (see 42 U.S.C. §1395b). The Medicare program generally, and the supplementary program covering physician services (Part B) in particular, were established to provide protection against the cost of medical care for the elderly.3/

As described by petitioners, Part B reimburses physicians for covered services they render to Medicare beneficiaries. The Medicare program will

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3/ Part B of the Medicare Act was described as "A voluntary supplementary plan ... providing protection against the costs of physicians' services and other medical and health services ...." S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 1945.

pay 80% of what it determines is the reasonable charge for those services.[4/]

Although Medicare is a national program and is uniform in the coverage it provides, it does not set nationally uniform rates. Through the formula established by the Act and its implementing regulations,[5/] the Medicare program

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4/ Petitioners claim that the reasonable charge set by Medicare is not "reasonable" because it is lower than actual charges. Pet. at 4 n. 2. However, actual charges are by no means the measure of what is reasonable. Physicians' actual charges are artifically inflated and result from monopolistic tendencies. C.A. App. 813-815. Congress recognized that full reimbursement of actual charges was inflationary, and in 1972 limited increases in the reasonable charge to a medical economic index. 42 U.S.C. §1395u(b)(3).

5/ See 42 U.S.C. §1395u(b)(3) and 42 C.F.R. §405.502(a).

has specifically recognized local variances in physician fees. The reasonable charge for each service is unique to that physician. Whatever the reasonable charge by a physician for a particular service may be, Medicare will pay 80 percent.

The Medicare beneficiary is responsible for the twenty percent of the reasonable charge that Medicare does not reimburse and, if the physician does not accept payment by "assignment," any amount sought by the physician over and above the reasonable charge. This additional amount is called the "balance bill" and the practice of charging patients in amounts over the reasonable charge is called "balance billing." If the physician accepts assignment of the claim, he cannot charge the patient more

than the reasonable charge. 42 C.F.R. §405.1675(A)(1)(i).[6/]

Petitioners point to 42 U.S.C. §1395u(b)(3)(B) as the primary Medicare provision with which Chapter 475 conflicts. This section does not create any right to reimbursement for the physician. See, e.g., Cervoni v. Secretary of HHS, 581 F.2d 1010, 1018 (1st Cir.

6/ As the Court of Appeals explained, the quid pro quo for accepting the reasonable charge as full payment is the security against bad debt, because the government assumes direct payment of 80 percent of the reasonable charge. App. 6a-7a.

In 1984 Congress sought to promote assignment by amending the Medicare Act to create a participating physician program. Under the program, a physician agrees to accept assignment of all the Medicare claims of his patients for a twelve-month period. In return, Congress provided various incentives to induce physicians to sign participating agreements. 42 U.S.C. §1395u(h), (i).

1978) (physicians derive no property interests from the Medicare program). Instead, the section provides direction to the local carrier as to methods of payment of the benefits due Medicare beneficiaries. The section directs the local carriers to pay the beneficiary "on the basis of an itemized bill," §1395u(b)(3)(B)(i), for services or to pay the physician if the beneficiary has assigned his rights to the physician and the physician has accepted the assignment §1395u(b)(3)(ii). At most, this section gives the physician an option as to method of payment: submit an itemized bill to the patient and accept the uncertainty of collection, or accept assignment and receive 80% of the charge from the government. There is nothing in this statute that guarantees the

physician anything as a result of his decision not to accept assignment. Certainly nothing in the section confers a right to balance bill. Other than determining what the federal government will pay, Congress had no intention of regulating physician fees or guaranteeing physicians freedom from state regulation. 42 U.S.C. §1395.

B. The Massachusetts Law

Chapter 475 has no effect on the administration of the Medicare program, nor does it affect the amount, timeliness, or conditions of federal reimbursement under Medicare. It does not compel the acceptance of assignment, affect the reasonable charge determination, preclude the direct billing of a patient, or man-

date that a physician become a participating physician. The state statute simply directs physicians licensed in Massachusetts to limit the fees they charge to elderly patients at the reasonable charge calculated under the Medicare Act. Put another way, they are prohibited from balance billing.

The ban on balance billing instituted by Chapter 475 closely resembles other protections that Massachusetts has extended to many of its citizens. In Massachusetts, all Blue Shield subscribers are protected against physician charges in excess of the Blue Shield-determined physician fee, Mass. G.L. c. 176B, §7, and Medicare beneficiaries who have purchased Medicare supplemental insurance (known as "Medex") are pro-

tected against physician charges in excess of the Medicare-determined reasonable charge. Mass. G.L. c. 176B, §6(f).[7/]

REASONS FOR DENYNG THE WRIT

The Court of Appeals' decision is correct and is wholly consistent with the decisions of this Court. There is no conflict between circuits which this Court must resolve. Since the Massachusetts law furthers the purposes of the Medicare Act, to protect the elderly against costs of medical care, and in no way has jeoparcized Medicare patients'

7/ The petitioners' statement that "Chapter 475 is not a law of general applicability," Pet. at 13, thus could be misleading in light of these other Massachusetts laws that also ban balance billing.

access to health care (App. 12a), there is no pressing issue of national importance that requires this Court's attention.

1. The Court Of Appeals Decision Is Consistent With Decisions Of This Court.

The decision below follows the preemption doctrine as set forth by this Court. There is no claim that Congress expressly intended to preempt state regulation of physician fees. App. 4a. Nor can it be said that Congress implicitly occupied the field of physician fee regulation, since the first section of the Act states a contrary intent. See 42 U.S.C. §1395; App. 4a. Rather, petitioners claim that Chapter 475 is preempted because it "stands as an obstacle to the accomplishment and execution of

the full purposes and objectives of Congress." Hines v. Davidowitz, 312 U.S. 52, 67 (1941). In analyzing this claim, the lower court correctly looked to determine the intent of Congress. App. 3a. California Federal Savings & Loan Ass'n v. Guerra, 107 S.Ct. 683, 689 (1987), Louisiana Public Service Commission v. F.C.C., 106 S.Ct. 1890, 1899 (1986). The Court of Appeals carefully examined all of the petitioners' evidence of legislative intent and found it insufficient to establish that Congress intended to create a right to balance bill insulated from state regulation. App. 8a. The court stated:

> [The petitioners'] evidence shows, with at least equal force, an intent simply to leave existing fee-setting practices undisturbed. And, this latter intention is per-

> fectly consistent with later decisions by individual states to regulate balance billing on their own. App. 8a.

The petitioners' principal argument is that the decision below "is based on a theory of preemption that conflicts with decisions of this Court holding state laws preempted when they nullify a federally created option embodied in a federal program." Pet. at 10. The alleged conflict is illusory, however. It rests on nothing more substantial than the petitioners' own theory of "federally created options," which differs from this Court's preemption analysis. The petitioners then proceed to give an unduly cramped reading to the decision of the Court of Appeals, as well as to decisions of this Court.

The Court of Appeals did not apply a "wooden requirement" that Congress must

"explicitly describe the option embodied in the statute as a right." Pet. at 12 and n. 8.[8/] Rather, the Court of Appeals sought to determine, from all the evidence, whether Congress intended to grant physicians a right to balance bill, or "a right to be immune from state interference". App. 5a, 13a. Accord, Rose v. Rose, 107 S.Ct. 2029, 2036-2038 (1987). The Court noted that the only

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8/ The Court of Appeals did not imply, as petitioners seem to suggest, that any particular explicit description appear in the statute. In addition to the word "right," the Court of Appeals looked to the text of the statute for "any other language suggesting creation of a right immune from state interference" or any "such language . . . in the legislative history." App. 9a. As preemption analysis is largely an exercise in statutory interpretation, it should not be remarkable that the Court of Appeals would look to the statute and its associated legislative history to determine whether Congress intended to create the very right the petitioners claim.

relevant "option" granted to the physicians in the Medicare Act is the option either to accept assignment of the patient's right to payment from the Medicare program or to receive payment from the patient by issuing an "itemized bill." App. 6a-9a. The federal "option," therefore, was not an option to balance bill in disregard of state law.

Indeed, by casting their argument in terms of an "option," the plaintiffs implicitly acknowledge the absence of a federal right to balance bill while, at the same time, trying to shift the focus away from the limited scope of the very "itemized bill" language upon which they rely. The petitioners' proposed distinction between an "option" and a "right" does not, however, advance the analysis

required for determining, as the Court of Appeals did (App. 5a, 8a, 9a), whether Congress intended to preclude states from banning balance billing.

In many of the cases cited by the petitioners, this Court has used the concept of a "right" in order to describe certain federally-created prerogatives that are free from state regulation. Rose v. Rose, 107 S.Ct. at 2036-2038, discussing Wissner v. Wissner, 338 U.S. 655, 658 (1950) (involving an express "right to designate the beneficiary" of a life insurance policy purchased under a federally-assisted program); Hisquierdo v. Hisquierdo, 439 U.S. 572 (1979) (Congress' determination that a retired railroad beneficiary should be the exclusive beneficiary of railroad retirement bene-

fits was described in Rose as a "right"); Ridgway v. Ridgway, 454 U.S. 46, 59-60 (1981) (As in Wissner, an Army officer had "an absolute right to designate the policy beneficiary"). The petitioners' attempt to turn the Court of Appeals' response to their "right/option distinction" into a conflict with decisions of this court is thus largely a matter of exploiting the various ways in which the word "option" can be used.9/ As shown by the cases just cited, this Court has not found this sort of semantic distinc-

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9/ The Court of Appeals described the ambiguity in the word "option" by referring to "the strong sense of that word: that Congress intended to create a legal right to balance bill, a right immune from significant state interference." App. 5a.

tion useful. Ultimately, it is the Congressional intent expressed in statutes that determines whether any particular right or option is to be given preemptive force.

To the extent that the petitioners' "option analysis" relies upon the broad definition of the word "option," it is inconsistent with well settled law. The only "option" arising from the Medicare Act is the option to engage in conduct that Congress did not expressly prohibit. Almost any choice that Congress does not prohibit individuals from making can be described as an option. Standing alone, such options do not evidence a Congressional intent to preempt state law. If they did, far fewer state laws could

survive preemption analysis.[10/]

10/ In the last term alone, at least five decisions of this Court upheld state laws that regulated or prohibited private parties with respect to exercising this type of "option." In California Coastal Commission v. Granite Rock Company, 107 S.Ct. 1419 (1987), the Forest Service issued a permit giving the Granite Rock Co. the "option" to conduct mining operations on federal lands, but California retained the power to require a state coastal development permit in order for mining operations under the federal permit to proceed. In CTS Corp. v. Dynamics Corp. of America, 107 S.Ct. 1637, 1647 (1987), the Williams Act allowed tender offerors the "option" to accept tendered shares after 20 business days, but Indiana retained the power to restrict this "option" by regulating in a way that impose additional delay. In Rose, supra, a veteran had the "option" to use his veterans' disability benefits as he saw fit, but the state retained the power to compel him to pay child support even if child support payments came from the federal benefit payments. In Fort Halifax Packing Company, Inc. v. Coyne, 107 S.Ct. 2211 (1987), the federal Employment Retirement Income Security Act of 1974 preserved the employer's pre-existing "option" to refuse severance payments, but Maine retained the power to

(footnote continued)

This leaves only the petitioners' attack on the Court of Appeals' decision by characterizing it as based on "subjective" judgment while ignoring the "objective" evidence of congressional intent. Pet. at 10. This characterization in no way reflects the lower court's careful analysis of that evidence. The objective evidence of lack of congressional intent to preempt state action came from the statute itself, 42 U.S.C.

(footnote continued)

require employers to make a one-time severance payment in the event of a plant closing. In California Federal Savings & Loan Ass'n v. Guerra, 107 S.Ct. 683 (1987), federal law left employers free to deny benefits to pregnant women to the extent that they did not grant such benefits to other disabled employees, but California retained the power to compel employers to provide an unpaid pregnancy leave of up to four months.

§§1395, 1395b, legislative debates,[11] and the lack of any suggestion in the legislative history that Congress intended a federal prohibition against state regulation of fees. App. 9a.[12]

11/ These debates led the lower court to conclude that ". . . this perception that the virtues of a balance billing ban vary from region to region seems to cut against [petitioners'] general claim that Congress meant to deny each state the freedom to deal with the matter as it sees fit." App. 11a-12a.

12/ Ironically, petitioners try to turn a Congressional intent to protect the elderly against high health care costs into a Congressional intent to protect doctors' ability to charge their elderly patients whatever they want. This argument is based on petitioners' prediction that a ban on balance billing will reduce access to health care for the elderly. Pet. at 7, 10. This argument was rejected both by the District Court after a trial on the merits and the Court of Appeals as factually unsubstantiated. App. 12a, 36a-43a.

Accordingly, the decision of the Court of Appeals is fully consistent with the decisions of this Court and for that reason no occasion for plenary review is presented.

2. There Is No Conflict Between The Lower Court Decision And Decisions Of Other Courts Of Appeals.

No other court of appeals or federal district court has decided the question of whether the Medicare Act preempts state action regulating physician fees to Medicare beneficiaries. Indeed, neither the petitioners nor the respondents have been able to find any federal court decision that holds any state action preempted by the Medicare Act.[13/]

13/ The only state court decisions that the parties have found uniformly uphold

(footnote continued)

This total lack of a conflict between circuits make this case inappropriate for review on the basis that ". . . a federal court of appeals has rendered a decision in conflict with the decision of another federal court of appeals on the same matter; . . ." Rule 17, Rules of the Supreme Court of the United States (emphasis added).

The petitioners attempt to manufacture a conflict by imposing their own interpretation upon two cases, Raskin

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(footnote continued)

various state laws against claims that those laws are preempted by the Medicare Act. Arnot-Ogden Memorial Hospital v. Axelrod, 516 N.Y.S. 2d 972 (A.D. 3 Dept. 1987); Wilkinson v. Madera Community Hospital, 144 Cal. App. 3d 436, 448, 192 Cal. Rptr. 593, 601 (1983); Subriar v. City of Bakersfield, 59 Cal. App. 3d 175, 207; 130 Cal. Rptr. 853, 873 (1976).

v. Moran, 684 F.2d 472 (7th Cir. 1982), and Roebling v. Office of Personnel Management, 788 F.2d 1544 (Fed. Cir. 1986), neither involving the Medicare Act and both arising in wholly different factual contexts. Neither case holds or implies that "options," loosely defined, preempt state law. Neither case was even cited to the Court of Appeals.14/

Obviously unable to point to a true conflict regarding the preemptive scope of the Medicare Act, the petitioners instead find a conflict in the "approach"

14/ Raskin held unconstitutional a Wisconsin statute that reduced certain judges' salaries by an amount equal to their Social Security benefits. Roebling held that a widow could not defeat her deceased husband's selection of civil service retirement benefits on the basis of her claim under California's community property law.

that they say the Raskin and Roebling courts took in resolving their respective preemption cases. But the approach of the lower court in this case is consistent with the decisions in Raskin and Roebling. All three opinions state that the intent of Congress is the starting point in determining whether state law conflicts with a federal law. Compare Raskin, 684 F.2d at 475, Roebling, 788 F.2d at 1546, and App. 3a. All three courts then ascertain the construction of the federal statute and the state statute and determine whether they are in conflict. Raskin at 475; Roebling at 1547-1548; and App. 6a-12a. The three courts came to different conclusions not because they took different approaches but because they were dealing with completely different statutes and therefore different congressional intentions.

In short, there is no conflict between circuits, let alone a "real and embarassing conflict," that would warrant review by this Court. Layne & Bowler Corp. v. Western Well Works, Inc., 261 U.S. 387, 393 (1923).

3. The Issue Presented Is Not Appropriate For Review At This Time.

Contrary to the petitioners' contentions, Chapter 475 does not subject the Medicare program to any state requirement. Consistent with the goals of the Medicare Act and cognizant of the unique health care environment in Massachusetts, this state statute regulates physician fees without disturbing the intent or the administration of the Medicare program.

Thus, while other states may have passed or are considering similar legislation these statutes present no threat to the Medicare Program.15/

15/ The petitioners seek to buttress their position by invoking the current Administration's lack of support for a federal mandatory assignment proposal. Pet. at 17 n. 11 and App. 62a. The Administration has, however, explicitly stated that that it does not object to balance billing legislation such as Chapter 475. Dr. William L. Roper, Director of the Health Care Financing Administration, testified on May 7, 1987, before the Subcommittee on Health of the House Committee on Ways and Means. When asked about the Administration's position on this very petition, he stated:

> We believe that mandatory assignment is not a good idea. The Commonwealth of Massachusetts is free to make those kind of judgments as it sees fit, even though we believe they are unwise, and we are not a party to that suit.

(footnote continued)

Even if the issue were of such importance to be considered by this Court, this would not be the appropriate time for review. As stated above, no other circuit court has considered this issue and no other similar legislation is even before a federal district court.[16/] As was stated in McCray v. New York, 461 U.S. 961, 963 (1983) (Stevens, J.): "... [I]t is a sound exercise of discretion for the Court to allow the [lower courts]

(footnote continued)

> States are free under the Federal system to make judgments, even though the Federal Government may think they are unwise. (Transcript of Subcommittee Hearing at 28, lines 645-651).

16/ Further, as petitioners note (Pet. at 17 n. 11), there is an active national debate concerning modification of Medicare's method of reimbursing physicians. Congress may soon take action that may moot or substantially modify the question presented here.

to serve as laboratories in which the issue receives further study before it is addressed by this Court." The respondents agree; the issue presented is not ripe for this Court's plenary review.

CONCLUSION

For the reasons stated above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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Dated: September 21, 1987